DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/24/15

PRINTED: 03/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	03/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

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F 000	INITIAL COMMENTS A recertification survey and complaint investigation #33259 and #34831, were completed on March 8-10, 2015, at Life Care Center of Jefferson City. No deficiencies were cited related to the complaint investigations under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	Life Care Center of Jefferson City is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide. While this plan is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted March 8—10 2015. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements.	4/24/15
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a comprehensive care plan for vision for one (#38) of three	F 279	**F279 DEVELOP COMPREHENSIVE CARE PLANS** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** To address the situation involving the facility's failure to develop a comprehensive care plan for vision for resident # 38, the resident was assessed on 3/10/15 and a comprehensive care plan for vision was developed by the IDT.	4/24/15 4/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer B Henderson | TITLE: Executive Director | (X6) DATE: 3/26/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 residents reviewed for vision of twenty-seven residents reviewed. The finding included: Resident #38 was admitted on November 22,2014, with diagnoses of Unspecified Closed Fracture of Ankle, Essential Hypertension, Chronic Pain, Difficulty in Walking, Esophageal Reflux, Diabetes Mellitus Type II, and History of Fall. Medical record review of the Quarterly Minimum Data Set (MDS) dated February 21, 2015, revealed the resident had moderately impaired-limited vision; not able to see newspaper headlines but can identify objects, and Corrective Lenses: Corrective lenses (contacts, glasses, or magnifying glass) used in completing Vision.B1200 = 0 (No). Medical record review of a Social Services Admission Assessment dated November 22, 2014, revealed no glasses but some mild impairment of vision. Medical record review of an Activities Evaluation dated November 24, 2014, revealed the resident had impaired/poor vision. Medical record review of the care plan revealed no interventions for the resident's vision. Interview with Certified Nursing Assistant (CNA #1), on March 10, 2015, at 10:10 a.m., in the resident's room revealed CNA #1 was not aware of the resident's impaired vision. Interview with Director of Nursing on March 10,	F 279	**How will you identify other residents having the potential to be affected by the same deficient practice?** All residents who have vision impairments will be reviewed by DON/RN/MDS/Activities/Social Services to determine if there is a comprehensive care plan for vision in place. Comprehensive care plans for vision will be developed for any/all identified residents by 4/10/15 by the IDT. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nursing staff/Social Services staff/Activities Director will be inserviced by the DON/RN/SDC on 3/27/15 to report any findings of visual impairment to an MDS coordinator immediately. MDS coordinators will be inserviced by the DON/RN/SDC on 3/27/15 to immediately develop an appropriate comprehensive care plan for vision for any resident found to have visual impairment. DON/ADON/RN will conduct weekly audits for six randomly chosen residents per week. These audits will be of MDS Section B for visual impairment and corresponding comprehensive care plans for vision. This will be done to ensure that all residents identified for visual	4/24/15

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F 279	Continued From page 2 2015, at 9:00 a.m., in the conference room confirmed the resident's care plan failed to address the resident's visual status.	F 279		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	**F356 POSTED NURSE STAFFING INFORMATION** **What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 3/8/14 immediately upon being notified that accurate nurse staffing was not posted for the current day, LPN #3 accurately updated posted nurse staffing information and each shift thereafter. **How will you identify other residents having the potential to be affected by the same deficient practice?** No additional residents have to potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur?** Licensed nurses will be inserviced by DON/SDC/RN on 3/27/15 as to how to accurately update the nurse staffing information and on the requirement to do this each shift. Cart #3 nurse will be responsible for completing this each shift.	4/24/15

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F 356	Continued From page 3 by: Based on observation and interview, the facility failed to post accurate nurse staffing information as required. The findings included: Observation on March 8, 2015, at 8:55 a.m., at the entrance hallway revealed the staffing information posted did not accurately reflect the nursing staff on duty for the current day. Observation of the posted staffing revealed the staffing information posted was the staff scheduled for Saturday, March 7, 2015, and had not been updated to reflect current nursing staff in the facility on March 8, 2015. Interview with the Licensed Practical Nurse #3, at the time of the observation on March 8, 2015, confirmed the staffing information did not reflect the current nursing staff present and confirmed the facility failed to post accurate staffing.	F 356	SDC/DON/RN will audit the staffing information posted daily to ensure accurate posting of nursing staffing across all shifts. **How will the corrective action be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?** SDC/DON/ADON will report findings of the audits to the interdisciplinary PI committee monthly for 12 weeks or until 100% compliance is achieved. The Performance Improvement committee includes the Executive Director, Director of Nursing, ADON, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, Director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Skilled MDS Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of these audits. If deemed necessary by the committee, additional education may be provided, and/or the process evaluated/revised.	4/24/15